Form 001 3/1/12

State of Utah - Labor Commission
Division of Adjudication
160 East 300 South, 3rd Floor, P.O. Box 146615
Salt Lake City, Utah 84114-6615
(801) 530-6800
casefiling@utah.gov
Note: PLEASE TYPE OR PRINT IN BLACK INK

_____ **Petitioner** _____ Other name(s) used by petitioner **vs.** _____ **Respondent (employer)** _____ Respondent's mailing address _____ City, State and Zip Code _____ Respondent's phone number _____ Respondent's workers' comp Insurance Carrier***** _____ Insurance Carrier's mailing address _____ City, State and Zip Code _____ Insurance Carrier's phone number	**APPLICATION FOR HEARING** **Industrial Accident Claim** (NOTE: Include all supporting documentation when this form is filed with the Labor Commission or the Application for Hearing may be returned) I request to have a **Claims Resolution Conference** scheduled to resolve the issues checked below ☐ **YES** ☐ **NO** *****It is the petitioner's obligation to provide the mailing address and phone number for respondent's insurance carrier. If you do not have this information you may obtain this information on the Labor Commission website, Industrial Accidents Division Workers' Compcheck or contact the employer or the Industrial Accidents Division.

PETITIONER ALLEGES AND REQUESTS RESOLUTION CONCERNING THE FOLLOWING UNDER TITLE 34A:

1. I sustained an injury by accident arising out of and in the course of my employment with the above named employer on the following date: Month_____Date_____Year_____.

2. The accident occurred at the following location:_____

3. The accident occurred as follows:
   _____
   _____
   _____

4. The injuries I sustained from the accident are:
   _____
   _____

5. Petitioner's birth date:_____

6. At the time of the accident at issue: my wage was $_____per_____, and I was working _____hours per week. I was_____was not_____married and had _____dependent children.

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APPLICATION FOR HEARING

7. I claim: (Please mark an "X" next to any issues you want resolved by hearing and attach relevant supporting documentation for each issue marked).

A. ☐ **Medical Expenses:** (specify the providers and amounts of unpaid medical expenses):
_____
_____
_____

B. ☐ **Recommended Medical Care:** (specify services or treatment):
_____

A. ☐ **Temporary Total Disability Compensation:** time off work from_____ to _____; from_____ to _____; from_____ to _____.

B. ☐ **Temporary Partial Disability Compensation:** reduced wages from_____ to _____; from_____ to _____; from_____ to _____.

C. ☐ **Permanent Partial Disability Compensation:** (specify impairment rating(s) for each injury:
_____
_____

F. ☐ **Permanent Total Disability Compensation:** permanent inability to work. (**Important:** you must complete the Permanent Total Disability Fact Sheet for permanent total disability compensation claims).

G. ☐ **Travel Expenses:** If you claim reimbursement for travel expenses you must attach a separate sheet with the name of the medical provider, the date(s) of service, and the mileage to the provider for each date.

H. ☐ **Unpaid Interest.**

I. ☐ **Other:** (specify):_____

Petitioner verifies that the above information is true and correct to the best of petitioner's information and belief.

_____ _____ Printed Name of Attorney for Petitioner State Bar #	_____ _____ **Signature of Petitioner** Date
_____ Signature of Attorney for Petitioner	_____ Mailing Address of Petitioner
_____ Mailing Address for Attorney for Petitioner	_____ City/State/Zip Code
_____ City/State/Zip Code	_____ Petitioner's Telephone Number
_____ Telephone Number	_____ Petitioner's Social Security Number
_____ _____ FAX E-Mail Address	_____ Petitioner's E-Mail Address

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DOCUMENTS THAT MUST BE FILED WITH APPLICATION FOR HEARING

***IMPORTANT*: Failure to include completed and signed forms with all requested supporting documentation will result in the Application for Hearing being returned for completion. If the returned Application for Hearing is not completed and re-filed with the requested supporting documents within sixty (60) days, the Application for Hearing will be dismissed.**

1. Form 307 Medical Treatment Provider List. (if you need additional space to list all medical providers you may attach an additional sheet)

2. Form 308 Authorization to Disclose Health Information.

3. Form 113a Summary of Medical Record. (Petitioner may submit other medical records that provide medical support for the claims of petitioner).

4. Form 152 Appointment of Counsel. (Only required if petitioner is represented by an attorney).

5. **Permanent Total Disability Fact Sheet.** (Only required if the claim is for permanent total disability compensation).

If you know the name and address of the adjuster or third party administrator that you have dealt with concerning your claim please include that information:

_____

Name of adjuster or third party administrator

_____

Mailing Address for adjuster or third party administrator

_____

City/State/Zip Code

_____

E-mail Address

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Permanent Total Disability Fact Sheet

You must complete this form if you are applying for permanent total disability compensation.

1. Date disability began:_____

2. Last grade completed in school:_____

3. Diplomas/degrees/licenses/or specialized training completed by petitioner:
   _____
   _____
   _____

4. Please state whether petitioner can speak and/or read and write in English:
   _____

5. Attach copies of written physical restrictions provided petitioner by your doctor that prevent or hinder your return to employment:

6. Please identify any jobs petitioner has worked or applied for since the industrial injury at issue in the present case:
   _____
   _____
   _____
   _____

7. **Petitioner's Employment History:** (attach additional sheets if necessary).

Employer	**Dates of Employment**	**Job Description**